TITLE 8. INDUSTRIAL RELATIONS
DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
CHAPTER 4.5. DIVISION OF WORKERS' COMPENSATION
SUBCHAPTER 1. ADMINISTRATIVE DIRECTOR -- ADMINISTRATIVE RULES
ARTICLE 5.5.1 UTILIZATION REVIEW STANDARDS

§ 9792.11 Investigation Procedures: Labor Code §4610 Utilization Review Violations

(a) To carry out the responsibilities mandated by Labor Code section 4610(i), the Administrative Director, or his or her designee, shall investigate the utilization review process of any employer, insurer or other entity subject to the provisions of section 4610**.** The investigation shall include but not be limited to review of the practices, files, documents and other records, whether electronic or paper, of the claims administrator***,*** and any other person responsible for utilization review processes ***for an employer***. ***As used in these regulations, the phrase 'utilization review organization' includes any person or entity with which the employer, or an insurer or third party administrator, contracts to fulfill part or all of the employer's utilization review responsibilities under Labor Code section 4610 and Title 8 of the California Code of Regulations, sections 9792.6 through 9792.15.***

(b) Notwithstanding Labor Code section 129 (a) through (d) and section 129.5 subdivisions (a) through (d) and sections 10105, 10106, 10106.1, ~~10107, 10107.1~~, 10108, 10110, 10111, 10111.1, 10111.2, and 10112 of Title 8 of the California Code of Regulations, the Administrative Director, or his or her designee, may conduct a utilization review process investigation pursuant to Labor Code section 4610, which may include but is not limited to an audit of files and other records.

~~(c) A utilization review investigation may, in the discretion of the Administrative Director, or his or her designee, be conducted as an independent investigation, or may be conducted concurrently with a Labor Code section 129 and 129.5 routine, target or full audit.~~

(c) The Administrative Director, or his or her designee, may conduct a utilization review investigation at any location where part or all of an employer's utilization review processes occur, as follows:

(1) A Routine Investigation shall be initiated at each known utilization review organization, or in the case of employer's performing utilization review on the employer's business site, no less frequently than once every three (3) years. A Routine Investigation of an employer's utilization review

processes also may be initiated at any claims adjusting location concurrently with a routine, target or full audit done pursuant to Labor Code section 129 or 129.5. A Routine Investigation of the utilization review processes handled at each claims adjusting location shall be done no less frequently than once every five (5) years.

(2) A Non-Routine Investigation may be conducted at any time:

(A) in the discretion of the Administrative Director or his or her designee, based on factual information or a complaint containing facts, indicating the possible existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.12 of these regulations, or

(B) to determine abatement of utilization review violations previously found.

(3) A Non-Routine Investigation based on factual information or a complaint containing facts may include:

(A) a review of the file or files pertaining to the alleged violation; and

(B) where the initial file review reveals violations, in the discretion of the Administrative Director or his or her designee, a sample of additional files to determine the prevalence of such violations.

(4) A Non-Routine Investigation to determine abatement may include:

(A) a review of a new sample of files containing utilization review decisions made after the date of the investigation that resulted in findings that required abatement; and

(B) a review of the files already investigated; and

(5) During any Non-Routine Investigation, the Administrative Director, or his or her designee, also may include investigation into any complaints received by the Administrative Director since the time of any prior investigation.

(d) Administrative penalties may be assessed for any failure to comply with Labor Code section 4610, or sections 9792.6 through ~~9792.10~~ ***9792.12*** of Title 8, California Code of Regulations. ***In the event an investigation of utilization review processes is done at the employer's claims adjusting location, concurrent with a routine, target or full audit done pursuant to Labor Code section 129 or 129.5, the administrative penalty amounts for each violation of Labor Code section 4610 or Title 8 of the California Code of Regulations, sections 9792.6 through 9792.12, shall be governed by sections 9792.11 through 9792.15 of Title 8. Any such administrative penalty for utilization review process violations shall apply in lieu of the administrative penalty***

amount allowed under the audit regulations at section 10111.2(b)(8)[vi] of Title 8, California Code of Regulations. In addition, any report of findings from the investigation and any Order to Show Cause re: Assessment of Administrative Penalties prepared by the Administrative Director, or his or her designee, based on violations of Labor Code section 4610 or Title 8 of the California Code of Regulations sections 9792.6 through 9792.12, shall be prepared separately from any audit report or assessment of administrative penalties made pursuant to Labor Code section 129 and 129.5. The Order to Show Cause re: Assessment of Administrative Penalties for violations of sections 9792.6 et seg of Title 8 of the California Code of Regulations shall be governed by the provisions sections 9792.11 through 9792.15 of Title 8.

(e) The Administrative Director, or his or her designee, may also utilize the provisions of Government Code sections 11180 through 11191 ***and sections 1822.50 et. seq. of the California Code of Civil Procedure*** ~~to carry out these responsibilities.~~ ***to determine whether any violations of the requirements in Labor Code section 4610 or sections 9792.6 through 9792.12 of Title 8, California Code of Regulations, have occurred.***

(f) ~~This section~~ ***Sections 9792.11 through 9792.15 of Title 8 of the California Code of Regulations*** shall apply to any Labor Code section 4610 utilization review investigation conducted on or after ~~August 1, 2006~~ ***the effective date of these regulations*** and to ~~actions~~ ***conduct*** which occurred on or after ~~August 1, 2006~~ ***the effective date of these regulations***

~~(g) The Administrative Director, or his or her designee, may conduct a utilization review investigation based on:~~

> ~~1) Factual information or a complaint containing facts, indicating the possible existence of a utilization review violation; or~~
> ~~2) By selection of any claims administrator by the Division as part of an audit pursuant to Labor Code section 129 or 129.5 from among the list of known claims adjusting locations.~~

(g) Notwithstanding the language within the audit regulations referring to investigations and/or audits pursuant to Labor Code sections 129 and 129.5, the following audit regulations may**,** in the discretion of the Administrative Director, or his or her designee, apply to investigations conducted pursuant to Labor Code section 4610: Title 8, California Code of Regulations, sections ***10100 through*** 10100.2; 10101, 10101.1; 10102; ***10103 –*** 10103.2; 10104; 10106.5; 10107~~(a), (b), (c)(2), (d), (e), (f), (g), (h), (i), (j), (k), (l), and (m)~~; ***10107.1*** ; and 10109.

~~(i)~~ ***(h)*** Any claims administrator***, utilization review organization*** or other person performing utilization review services for an employer, ***that possesses or is***

able to obtain the employer's current legal name, address and phone number, shall provide ***this information to*** the Administrative Director, or his or her designee, ~~the current legal name, address, and phone number of the employer,~~ upon request.

(i) Upon receipt of any final report of findings of violations of Labor Code 4610 or sections 9792.6 through 9792.12 of Title 8 of the California Code of Regulations from the Administrative Director, or his or her designee, the claims administrator, utilization review organization or other person performing utilization review services for an employer shall notify affected employers by the following means:
(1) The notice shall include a summary of the Division's findings on investigation, the measures actually implemented to abate such conditions, whether an objection or appeal is being filed from any Order to Show Cause re: Administrative Penalties and the website address for the Division where the final investigation report is posted.
(2) For each utilization review file, claim or request that was the basis for a specific finding of violation, the affected employer for that case, claim or request shall receive the notice required by section 9792.11(i)(1) above by certified mail; and
(3) The Administrative Director or his or her designee shall post a copy of the final report on the website for the Division of Workers' Compensation.

~~(j) Within 5 calendar days of the request, any claims administrator or employer, or third party administrator, or other person performing utilization review services for an employer shall provide the Administrative Director, or his or her designee, from all source locations all records involving the utilization review process under investigation.~~

~~(j)~~ ***(j) Unless the Administrative Director in his or her discretion determines that advance notice will render an investigation less useful, the claims administrator, utilization review organization or other person performing utilization review processes for an employer will be notified no less than thirty (30) calendar days in advance of the date for commencement of an onsite routine or non-routine investigation. Upon receipt of the notice of a routine or non-routine investigation, the claims administrator, utilization review organization or other person performing utilization review processes for the employer shall, within seven (7) calendar days, deliver to the Administrative Director, or his or her designee, all requested information and records, including but not limited to:***

(1) A description of the system used to uniquely identify each utilization review request, which includes but is not limited to each request for authorization for treatment services or pharmaceutical drugs or durable

medical equipment or diagnostic tests or exams, and the method used to track the status of the request;
(2) A description of all media used to transmit, share, record or store information received and transmitted in reference to each request, whether printed copy, electronic, fax, diskette, computer drive or other media;
(3) A legend of any and all numbers, letters and other symbols used to identify the disposition (e.g. approve, deny, modify, delay or withdraw) for individual utilization review requests;
(4) A summary depicting the total number of utilization review requests communicated to and the total number of utilization review dispositions issued from the site of the investigation, which summary also shall display the number of dispositions by type resulting in approval, denial, modification, delay or withdrawal of the request, respectively. In the cases involving the withdrawal of a request during the reporting period specified by the Administrative Director, or his or her designee, the summary shall include the number of instances, displayed by type of person making the withdrawal, according to those withdrawn by the requesting physician, withdrawn by the injured employee or employee's attorney, withdrawn by the claims adjuster and withdrawn by any other person;
(5) A depiction of the organization's hierarchy, which may be satisfied by a copy of the organizational chart, which depiction shall include but not limited to the place of the medical director within the organization, and of the line of authority from the highest management level of the organization to the medical director responsible for all utilization review decisions. The depiction or chart provided also shall include the hierarchy and line of authority from the medical director to all other persons involved in receiving, processing, evaluating, reviewing and responding to requests for authorization;
(6) A description of the methods by which the medical director for utilization review is advised of and able to be responsible for all decisions made in the utilization review process, as required by sections 9792.6(l) and 9792.7(b) of Title 8 of the California Code of Regulations;
(7) A list of each and every utilization review case or request received at the investigation site during the time period specified by the Administrative Director, or his or her designee. The list shall be in an electronic format acceptable to the Administrative Directive, or his or her designee, and shall include at a minimum the following data elements: i) a unique identifying number for each file, case or request; ii) the claim number used by the claims adjuster; iii) the initial date of receipt of the request for medical treatment; iv) the type of review (prospective, concurrent, retrospective, expedited, appeal); v) the disposition (approve, deny, delay, modify, withdrawal); and, vi) if applicable, the type of person who withdrew the request (requesting physician, claims adjuster, injured employee or his or her attorney, or other person). In the event the claims administrator, utilization review organization or other person subject to Labor Code

section 4610 is not able to provide the list in an electronic format, the list shall be provided in such a form that the listed files, cases or requests are sorted in the following order: by type of utilization review; type of disposition; and date of receipt of the initial request.

(8) The following additional data elements, if available, may be requested by the Administrative Director or his or her designee: i) the name of the utilization review organization or person subject to Labor Code section 4610; ii) whether utilization review services are provided externally; iii) whether utilization review services are provided by more than one contractor; iv) if a third party administrator is being used, the employer or insurer name and address; v) the name and address of the employer; vi) the name and address of the claims adjuster handling the claim that gave rise to the request for medical treatment; vii) the date the request was sent by the claims adjuster to the utilization review organization (if applicable); viii) the date of the decision by the utilization review organization or other person performing utilization review services for the employer; ix) the name of the requesting physician; x) the date the requesting physician was notified of the decision; and xi) the medical treatment, product or service requested.

(k) Based on the information provided pursuant to section 9792.11(i) above, the Administrative Director, or his or her designee, shall provide the claims administrator, utilization review organization or other person subject to Labor Code section 4610, with a list of no less than thirty-two (32) specific individual utilization review files, cases or requests, for investigation. Within seven (7) calendar days of receipt from the Administrative Director, or his or her designee, of the list of utilization review files, cases or requests for investigation, the claims administrator, utilization review organization or other person performing utilization review services for the employer shall:

(1) Deliver to the Administrative Director, or his or her designee, a true and complete copy of all records, whether electronic or paper, for each utilization review file, case or request listed. The records may be copied and tendered, or provided in their original form, to the Division, and shall be delivered with a statement signed under penalty of perjury by the custodian of records for the location at which the records are held, attesting that the all of the records produced are true, correct and complete copies of the originals, or are the original records, in his or her possession;

(2) In the case of a utilization review investigation being conducted concurrently with a routine, target or full audit pursuant to Labor Code sections 129 or 129.5, the employer shall produce for the Administrative Director, or his or her designee, on the first day of commencement of the onsite investigation, the true, correct and complete original records,

whether electronic or paper, whether located onsite or offsite, for each utilization review case, file or request identified by the Administrative Director or his or her designee, together with a statement signed under penalty of perjury by the custodian of records for the location at which the records are held, attesting that all of the records produced are true, correct and complete copies of the originals, or that the records are the originals.

(l) Beginning on the first day of any onsite investigation, the claims administrator, utilization review organization or other person subject to Labor Code section 4610 shall make the original files, whether electronic or paper, of all records previously copied pursuant to subdivision 9792.11(j) above, available for review by the Administrative Director, or his or her designee. In the event the Administrative Director, or his or her designee, determines additional records or files are needed for review during the course of an onsite investigation, the claims administrator, utilization review organization or other person performing utilization review for an employer shall produce the requested records in the manner described by subdivision 9792.11(j) above, within one (1) calendar day when the records are located at the site of investigation, and within five (5) calendar days when the records are located at any other site. Any such request by the Administrative Director, or his or her designee, also may include records or files pertaining to any complaint alleging violations of Labor Code sections 4610 or sections 9792.6 through 9792.12 of Title 8 of the California Code of Regulations. ~~Within 5 calendar days of the request, any claims administrator or , employer, or third party administrator or other person performing utilization review services for an employer shall provide the Administrative Director, or his or her designee, from all source locations all records involving the utilization review process under investigation.~~ ***The Administrative Director, or his or her designee, may extend the time for production of the requested records for good cause.***

~~(k)~~ ***(m)*** For the purposes of assessing penalties, ***and except in cases involving concurrent or expedited review,*** if the date or deadline ***in sections 9792.9(b) and 9792.9(c) of Title 8 of the California Code of Regulations*** to perform any act related to utilization review practices falls on a weekend or holiday, the act may be performed on the first business day after the weekend or holiday~~, except that . the~~ ***The*** timelines in section~~s~~ 9792.9(b) ~~and 9792.9(e)~~ of Title 8 of the California Code of Regulations shall only be extended as provided under section 9792.9(g) of that title***.***

~~(l)~~ ***(n)*** If the claims administrator***, utilization review organization*** or other person performing utilization review services for the employer does not record the date a document is received, it shall be deemed received ~~on the same day as the latest date the sender wrote on the document for information conveyed by telephone or facsimile. Documents sent via US mail shall be deemed received~~

~~no later than five calendar days after the latest date the sender wrote on the document~~ ***by using the method set out in section 9792.9(a)(2), except that:***

(1) where the request for authorization is made by mail through the U.S. postal service and no proof of service by mail exists, the request shall be deemed to have been received by the claims administrator, utilization review organization or other person subject to the requirements of Labor Code section 4610 on whichever date is earlier, either the receipt date stamped by the addressee or within five (5) calendar days of the date stated in the request for authorization or where the addressee can show a delay in mailing by the postmark date on the mailing envelope then within five (5) calendar days of the postmark date, if the place of mailing and place of address are both within California, within ten (10) calendar days if the place of address is within the United States but outside of California, and within twenty (20) calendar days if the place of address is outside of the United States; and

(2) where the request for authorization is made by express mail, overnight mail or courier without any proof of service, the request shall be deemed received by the addressee on the date specified in any written confirmation of delivery.

(o) Upon initiating an investigation ~~into an alleged violation~~ pursuant to ***Title 8 of the California Code of Regulations,*** ~~section 9792.12(a)~~ ***9792.11(c)(2)*** ~~of these regulations~~ ***into an alleged violation***, ***and solely in the exercise of his or her discretion,*** the Administrative Director, or his or her designee, may provide ***to*** the claims administrator***, the utilization review organization*** or other ~~entity~~ ***person*** subject to Labor Code section 4610 ~~with~~ a written description of the factual information or of the complaint containing factual information that ~~has~~ triggered the utilization review investigation. ***The Administrative Director, or his or her designee, may refuse to provide such a written description, whenever the Administrative Director or his or her designee determines that providing the information would make the investigation less useful.*** The claims administrator***, utilization review organization*** or other ~~entity~~ ***such person*** shall have ten (10) business days upon receipt of the written description to provide a written response to the Administrative Director or his or her designee. After reviewing the written response, the Administrative Director, or his or her designee, shall either close the investigation without the assessment of administrative penalties or conduct further investigation to determine whether ***a violation exists and whether*** to impose penalty assessments.

(p) The files and other records, whether electronic or paper, that pertain to the utilization review process for an employer or the employer's claims administrator, utilization review organization or other person performing utilization review for the employer, shall be retained for at least five (5)

years following either: i) the most recent utilization review decision for each injured employee, or ii) the date on which any appeal from the assessment of penalties for violations of Labor Code section 4610 or sections 9792.6 through 9792.12 is final, whichever date is later.

(g) For all files and other records pertaining to the employer's utilization review process, whether electronic or paper, that are created or held outside of California, upon receipt of a notice of Routine or Non-Routine Investigation or any other request from the Administrative Director, or his or her designee, to review such files or other records, the claims administrator, utilization review organization or other person performing utilization review services for an employer, shall either deliver all such requested files and other records to an address in California specified by the Administrative Director, or his or her designee, or reimburse the Administrative Director for the actual expenses of each investigator who travels outside of California to the place where the original records are held, including the per diem expenses, travel expenses and compensation for such personnel including overtime.

Authority: ***Sections 11180 – 11191, Government Code;*** Sections 133, 4610, and 5307.3, Labor Code.
Reference: ***Sections 1822.50 et seq, Code of Civil Procedure;*** Sections 129, 129.5, 4062, 4600, 4600.4, 4604.5, 4610, and 4614, Labor Code.

§ 9792.12 *Administrative* Penalty Schedule for Labor Code §4610 Utilization Review Violations

(a) Single Instance ***Mandatory Administrative*** Penalties. Notwithstanding Labor Code section 129.5(c)(1) through (c)(3), the penalty ***amount that shall be assessed*** for each failure to comply with the utilization review process required by Labor Code section 4610 and ~~the applicable regulations~~ ***sections 9792.6 through 9792.12 of Title 8 of the California Code of Regulations,*** is:

(1) A maximum of $50,000 for failure to establish a utilization review process~~,~~ ***and*** to file ***with the Administrative Director*** a ***written plan that describes the*** utilization review ***process,*** ~~plan and~~ ***or for failure*** to maintain a utilization review process***,*** ~~in compliance with Labor Code section 4610, including the failure to include~~ ***that complies with*** all of the following ~~required information~~ ***requirements of Labor Code section 4610***:

> (A) The ***plan states, and at any time upon request, the claims administrator, utilization review organization or other person performing utilization review services for the employer, can provide the*** name, medical license number, and current areas of certified specialty

and practice, of the ~~employed or designated~~ ***permanent or acting*** medical director ***for the plan***, who holds an unrestricted license to practice medicine in the state of California issued pursuant to section 2050 or section 2450 of the Business and Professions Code.– ***and who is employed, within the meaning of Labor Code section 3351 or Labor Code section 3353, with the express written authority and responsibility for all utilization review decisions made for the employer, as required by section 9792.6(l) and in compliance with section 9792.7(b),Title 8 of the California Code of Regulations.***

(B) ***The plan states, and at any time upon request, the claims administrator, utilization review organization or other person performing utilization review services for the employer, can provide*** ~~A~~ ***a written*** description of the process whereby requests for authorization are reviewed, and decisions on such requests are made, and a description of the process for handling expedited reviews.

(C) ***The plan states, and at any time upon request, the claims administrator, utilization review organization or other person performing utilization review services for the employer, can provide*** ~~A~~ ***a written*** description of the specific criteria utilized in the review and throughout the decision-making process, including treatment protocols or standards used in the process for both routine and non-routine reviews, and as otherwise required by section 9792.7 of Title 8 of the California Code of Regulations.

(D) ***The plan states, and at any time upon request, the claims administrator, utilization review organization or other person performing utilization review services for the employer, can provide*** ~~A~~ ***a written*** description of the ***qualifications*** and functions of ~~the~~ ***all*** personnel involved in decision-making ~~and~~ ***or in*** implementation of the utilization review plan and process.

(E) ***The plan states, and at any time upon request, the claims administrator, utilization review organization or other person performing utilization review services for the employer, can provide*** ~~A~~ ***a written*** description, if applicable, of any prior authorization process in the utilization review plan or process.

(2) A maximum of $ 50,000 for failing to employ a physician as a medical director in section 9792.6(l) of Title 8 of the California Code of Regulations, whether employed in a permanent or acting capacity, who has the express authority and responsibility for all utilization review decisions issued on

the employer's behalf, as required by sections 9792.6(l) and 9792.7(b) of Title 8.

~~(2) A maximum of $10,000 for failure to have as the medical director of the utilization review process a physician who holds an unrestricted license to practice medicine in the state of California issued pursuant to section 2050 or section 2450 of the Business and Professions Code.~~

~~(3)~~ ***(3)*** A maximum of ~~$5,000~~ ***$ 25,000*** for a decision to modify or deny a request for authorization based on the opinion of a reviewer, whether the medical director, expert reviewer or ***other*** reviewer, regarding a medical treatment, procedure, service or product that is outside of the scope of practice ~~or professional competence~~ of the reviewer who made the decision.

~~(6)~~ ***(4)*** A maximum of ~~$5,000~~ ***$ 25,000*** if a ***non-physician reviewer (person other than a reviewer, expert reviewer or medical director as defined in section 9792.6 of Title 8 of the California Code of Regulations)*** makes ~~a~~ decision to delay, ~~modify~~ or deny a treatment authorization request ***without obtaining the opinion of a reviewer for that case***.

(5) A maximum of $ 25,000 if a non-physician reviewer (person other than a reviewer, expert reviewer or medical director as defined in section 9792.6 of Title 8 of the California Code of Regulations) modifies a request for treatment without possessing at the time of approving the modification an amended written request for treatment authorization as provided under section 9792.7(b)(3) of Title 8 of the California Code of Regulations.

~~(9)~~ ***(6)*** A maximum of ~~$5,000~~ ***$ 25,000*** for failing to authorize and to provide all medical treatment***, as required by Labor Code section 5402(c),*** consistent with ***the medical treatment utilization schedule adopted pursuant to*** Labor Code section 5307.27 ~~or the ACOEM practice guidelines~~***,*** until either the claim has been accepted, rejected or the dollar threshold in Labor Code section 5402(c) has been paid.

(7) A maximum of $ 15,000, in the event of a request for an expedited review, as defined in section 9792.6(g) of Title 8 of the California Code of Regulations, for the failure to make and communicate the decision in a timely fashion, as required by section 9792.9 of Title 8.

~~(5)~~ ***(8)*** A maximum of ~~$5,000~~ ***$ 10,000*** if the request for authorization is denied solely on the basis that the ~~requested treatment~~ ***condition for which treatment was requested*** is not addressed by ~~ACOEM or, after a~~ ***the*** medical ***treatment*** utilization schedule ~~has been~~ adopted pursuant to section 5307.27 of the Labor Code, ~~on the sole basis that it is not addressed by that medical treatment utilization schedule, when~~ ***after*** the requesting physician has provided the

specific clinical rationale for the requested treatment and has provided or referred to relevant page(s) of other evidence-based medical treatment guidelines that are generally recognized by the national medical community and are scientifically based.

~~(8)~~ ***(9)*** A maximum of ~~$5,000~~ ***$ 10,000*** in the case of concurrent review, for denying authorization of or discontinuing medical care, prior to discussing with the requesting physician reasonable options for a care plan and making a good faith effort to agree on a care plan as required by Labor Code section 4610(g)(3)(B).

~~(4) A maximum of $5,000 if the request for authorization is modified or denied by a reviewer, whether the medical director, expert reviewer or reviewer, who fails to state the portion of the medical criteria or guidelines relied on that is relevant to the injured employee's condition and to the requested treatment, as well as the clinical reasons for the decision and the reviewer's conclusion regarding medical necessity.~~

~~(7)~~ ***(10)*** A maximum of ~~$5,000~~ ***$ 10,000*** for failing to respond to the request for authorization by the ***injured*** employee's ***requesting treating*** physician.

~~(10)~~ ***(11)*** A maximum of ~~$1,000~~ ***$ 5,000*** for failure to file with the Administrative Director, a complete and current copy of the utilization review plan or a letter in lieu of a utilization review plan as required by section 9792.7(c) ***or for failure to file, within thirty (30) days after making a material modification to the plan,*** ~~with the Administrative Director~~ a complete and current copy of the ***modified*** utilization review plan or a letter in lieu of a utilization review plan as required by section 9792.7(c) ~~of these regulations~~ ***of Title 8 of the California Code of Regulations***.

(12) A maximum of $ 1,000, in the event that a request for authorization is approved pursuant to Labor Code section 4610 or sections 9792.6 through 9792.12 of Title 8 of the California Code of Regulations, without providing the requesting physician at the time of approval with either an authorization number or a unique identifying number that links the approved medical treatment authorization to a specific claim made by an injured employee.

(b) Additional Penalties and Remediation.

(1) For the types of violations listed below, each violation shall have a basic penalty amount, as specified of $ 100 in (b)(3) or $ 50 in (b)(4). The basic penalty amount shall be waived only the first time the violation is found at

the investigation site and only upon the condition that the employer, claims administrator, utilization review organization or other person performing utilization review for that location, agrees in writing to:

(A) Deliver to the Administrative Director, or his or her designee, within no more than thirty (30) calendar days or the number of days otherwise specified, written evidence, tendered with a declaration made under penalty of perjury, that explains or demonstrates how the violation has been abated in compliance with the applicable statute or regulations and the terms of abatement specified by the Administrative Director; and

(B) Grant the Administrative Director, or his or her designee, entry, upon request and regardless of advance notice, to the site at which the violation was found for a Non-Routine Investigation for the purpose of verifying compliance with the abatement measures reported in subdivision 9791.12(b)(1)(A) above; and

(C) Reinstatement of the full basic penalty amount previously waived for each such instance, in the event the violative condition is not abated within the time period specified by the Administrative Director, or his or her designee, or in the event that such abatement measures are not consistent with abatement terms specified by the Administrative Director, or his or her designee; and

(D) That whenever the full basic penalty amount has been reinstated pursuant to subdivision 9791.12(b)(1)(D) above, also to reimburse to the Administrative Director the reasonable costs of any Non-Routine Investigation visit conducted for the purpose of verifying compliance with the specified abatement measures. Any such reimbursement shall include the expenses for travel, per diem and compensation paid to investigation team personnel, including overtime if any.

(2) In the event the Administrative Director, or his or her designee, returns to the same investigation site, after the initial violation has become final, and finds one or more violations of the same section of Labor Code section 4610 or sections 9792.6 through 9792.12 of Title 8 of the California Code of Regulations, the amount of penalty, assessed for each instance of same violation found, shall be calculated as described below and in no event shall the penalty amount be waived:

(A) A maximum of the basic penalty amount times 10% of the total number of utilization review requests answered in the 30 days preceding notice of, or onset of, a non routine (follow up) or second investigation at this location, plus reimbursement to the Division of its reasonable costs of investigation;

(B) A maximum of the basic penalty amount times 20% of the total number of utilization review requests answered in the 30 days

preceding notice of, or onset, of a non routine (follow up) or third investigation at this location, plus reimbursement to the Division of its reasonable costs of investigation;

(C) A maximum of the basic penalty amount times 40% of the total number of utilization review requests answered in the 30 days preceding notice of, or onset of, a non routine (follow up) or third investigation at this location, plus reimbursement to the Division of its reasonable costs of investigation.

(3) For each of the violations listed below, the basic penalty amount shall be a maximum of $ 100.00 for each instance found by the Administrative Director, or his or her designee, at that location:

(A) If the request for authorization is modified or denied by a physician reviewer who fails to state the portion of the medical criteria or guidelines relied on that is relevant to the injured employee's condition and to the requested treatment, or the reviewer fails to state the clinical reasons for the decision and the reviewer's conclusion regarding medical necessity;

(B) Failure to notify the requesting physician and the injured worker and his or her attorney, if any, immediately and in writing, as required by section 9792.9(g)(2) of Title 8 of the California Code of Regulations, that the time for decision is being formally extended, as well as stating which of the grounds in section 9792.9(g)(1) of Title 8 for an extension applies;

(C) In the case of a denial of authorization on the basis of a lack of necessary and reasonable information, for failure to document contemporaneously, as required by section 9792.9(l) of Title 8 of the California Code of Regulations, the request for additional medical information made to the requesting physician or to the provider of goods or services identified in the request for authorization;

(D) Upon receipt of information that gave rise to a formal delay pursuant to section 9792.9(g)(1)(A), 9792.9(g)(1)(B) or 9792.9(g)(1)(C), or upon receipt of information that gave rise to a delay pursuant to section 9792.9(b)(2)(A) of Title 8 of the California Code of Regulations, for failure of the claims administrator to make a decision to approve or for failure by the reviewer to make a decision to modify or deny the request for authorization, within five (5) working days of receipt of the information for prospective or concurrent review, or for failure to communicate the decision as required by section 9792.9(g)(3) of Title 8.

(E) In the case of retrospective review, after receipt of information that gave rise to a formal delay pursuant to section 9792.9(g)(1)(A), 9792.9(g)(1)(B) or 9792.9(g)(1)(C) of Title 8 of the California Code of Regulations, for failure by the claims administrator to make a decision to approve or for failure of the reviewer to make a decision to modify or deny the request, within thirty (30) working days of receipt of the information, as required by section 9792.9(g)(4) of Title 8.

(F) For failure, by the claims administrator, utilization review organization or other person performing utilization review services for an employer, to include in the written decision that modifies, delays or denies authorization, all of the following items required by subdivision 9792.9(j) of Title 8 of the California Code of Regulations:

(1) The date on which the decision was made;

(2) A description of the specific course of proposed medical treatment or the medical services for which authorization was requested;

(3) A specific description of the medical treatment service approved, if any;

(4) A specific description of the course of medical treatment and each medical service delayed, modified or denied in whole or part.

(5) A clear and concise explanation of the reasons for the decision to delay, modify or deny each item requested.

(6) A written disclosure or copy of the relevant portion of the medical criteria or guidelines relied upon pursuant to section 9792.8(a)(3) of Title 8 of the California Code of Regulations by the reviewer, whether done by the medical director, expert reviewer or reviewer, in making the decision to modify, delay or deny requested treatment;

(7) The clinical reasons provided by the reviewer, whether the medical director, expert reviewer or reviewer, regarding medical necessity;

(8) A clear statement in compliance with section 9792.9(j)(7) of Title 8 of the California Code of Regulations regarding the time

limits and the process for resolving disputes in accordance with Labor Code section 4062;

(9) The mandatory language required by section 9792.9(j)(8) of Title 8 of the California Code of Regulations; and

(10) The name and specialty of the reviewer, expert reviewer or medical director that made the decision to modify, delay or deny the requested treatment, along with his or her telephone number in the United States, and hours of availability in accordance with section 9792.9(k) of Title 8 of the California Code of Regulations.

(G) For each failure by the claims administrator, utilization review organization or other person performing utilization review services for an employer to disclose or otherwise to make available, if requested, the Utilization Review criteria or guidelines, to the injured employee whose case is under review or to the public, as required by Labor Code section 4610, subdivision (f)(5) and, respectively, sections 9792.8(a)(3) and 9792.7(d) of Title 8 of the California Code of Regulations.

(4) For each of the violations listed below, the basic penalty amount shall be a maximum of $ 50.00 for each instance found by the Administrative Director, or his or her designee, at that location:

(A) Failure by non-physician or physician reviewer to notify the requesting physician timely, as required by section 9792.9(b)(2) of Title 8 of the California Code of Regulations, that additional information is needed in order to make a decision in compliance with the timeframes contained in section 9792.9(b);

(B) In the case of prospective or concurrent review, failure to communicate the decision to approve to the requesting physician, by phone or fax within 24 hours of the decision, as required by Labor Code section 4610(g)(3)(A) and in accordance with section 9792.9(b)(3) of Title 8 of the California Code of Regulations;

(C) In the case of decisions to modify, delay or deny in whole or in part any requested treatment, for the failure to send a written notice of the decision to the requesting physician, to the provider of goods or services identified in the request for authorization, and to the injured employee and to his or her attorney if any, within twenty four (24) hours of making the decision for concurrent review, or within

two business days for prospective review, as required by Labor Code section 4610(g)(3)(A) and section 9792.9(b)(4) of Title 8 of the California Code of Regulations;

(D) In the case of retrospective review, for the failure to communicate a decision as required by section 9792.9(c) Title 8 of the California Code of Regulations, to the requesting physician who provided the medical services and to the injured worker and his or her attorney, if any, or to the non-physician provider of goods or services identified in the request, within thirty (30) calendar days of receipt of the medical information that was reasonably necessary to make the determination;

(E) For each failure by the claims administrator to provide immediately a written notice to the requesting physician, to the injured employee, and to his or her attorney if any, that a decision on the request for authorization cannot be made within fourteen (14) days for prospective and concurrent reviews, or within thirty (30) days for retrospective reviews for one of the reasons stated in Labor Code section 4610(g)(5) and in accordance with section 9792.9(g)(2) of Title 8 of the California Code of Regulations;

(F) For each instance in which a claims administrator, in reliance on Labor Code section 4610(g)(5), delays making or communicating a timely decision or extends the time for decision pursuant to section 9792.9 of these regulations on a request for authorization for medical services, and the claims administrator cannot provide documentation showing one of the following events occurred prior to or at the time the claims administrator communicated this reason for delay under Labor Code section 4610(g)(5):

1) the claims administrator had not received all of the information reasonably necessary and requested;

2) the employer or claims administrator has requested a consultation by an expert reviewer;

3) the physician reviewer has requested an additional examination or test be performed;

(G) For each instance in which the claims administrator communicates, in reliance on Labor Code section 4610(g)(5), a written decision to delay or to extend the time for making a decision on a request for authorization for medical services, but fails to state one or more of the following, as appropriate, to explain the reason for delay as required by section 9792.9(g)(1) of Title 8 of the California Code of Regulations:

1) the necessary medical information reasonably requested but not received; or
2) the name and specialty of the expert reviewer to be consulted; or
3) the additional test(s) or examination(s) to be performed that is reasonable and consistent with professionally recognized standards of medical practice; AND
4) the anticipated date on which a decision will be made.

(5) The Administrative Director, or his or her designee, may post on the website for the Division of Workers' Compensation the name and final penalty amount(s) paid by each claims administrator, utilization review organization or other person performing utilization review services for the employer. For the purposes of this subdivision, the final penalty amount means the actual amount paid or the amount due and payable after any or all appeals have become final.

(6) The phrase 'reasonable costs' of investigation of the Administrative Director, or his or her designee, for the purposes of section 9792.12 shall include the actual per diem expenses, travel expenses and compensation paid for the investigation team personnel, including overtime if any, for the time spent on site during the investigation.

(c) The penalty amounts specified for violations under subsection 9792.12(a) above may, in the discretion of the Administrative Director, be reduced after consideration of the factors set out in section 9792.13 of Title 8 of the California Code of Regulations. Failure to abate a violation found under section 9792.12(a), in the time period or in a manner consistent with that specified by the Administrative Director, or his or her designee, shall result in the assessment of the full original penalty amount proposed by the Administrative Director for that violation.

~~(1) For each instance in which an expedited review decision is requested and appropriate, for the failure to make a decision in a timely fashion, not in excess of 72 hours after receipt of the information reasonably necessary to make the determination:~~

~~(A) $200 for 10 or fewer violations;~~

~~(B) $800 for 11 to not more than 20 violations;~~

~~(C) $3,200 for 21 to not more than 40 violations;~~

~~(D) $6,400 for more than 40 violations.~~

(2) For each failure to notify the requesting physician, the provider of services or goods identified in the request for authorization, the injured employee, and his or her attorney, if any, that additional information is needed in order to make a decision in compliance with the timeframes contained in section 9792.9 of Title 8 of the California Code of regulations:

(A) $200 for 10 or fewer violations;

(B) $800 for 11 to not more than 20 violations;

(C) $3,200 for 21 to not more than 40 violations;

(D) $6,400 for more than 40 violations.

(3) For each denial of authorization on the basis of lack of information, where the claims administrator fails to make contemporaneous documentation reflecting his or her request for the necessary reasonable information from the requesting physician, the provider of goods or services identified in the request for authorization, or other person having the information:

(A) For request for concurrent authorization:

(1) $200 for 10 or fewer violations;

(2) $800 for 11 to not more than 20 violations;

(3) $3,200 for 21 to not more than 40 violations;

(4) $6,400 for more than 40 violations.

(B) For requests for prospective authorization:

(1) $100 for 10 or fewer violations;

(2) $400 for 11 to not more than 20 violations;

(3) $1,600 for 21 to not more than 40 violations;

(4) $3,200 for more than 40 violations.

(C) For requests for retrospective authorization:

(1) $50 for 10 or fewer violations;

(2) $200 for 11 to not more than 20 violations;

(3) $800 for 21 to not more than 40 violations;

(4) $1600 for more than 40 violations.

(4) $500 for the claims administrator's failure to include one or more of the following items*:* in the written decision modifying, delaying or denying authorization for medical services which is provided to the requesting physician, the provider of goods or services identified in the request for authorization, the injured worker, and his or her attorney, if any:

(A) The date on which the decision was made;

(B) A description of the specific course of treatment or the medical services for which authorization was requested;

(C) A specific description of the course of treatment and medical services approved, if any.

(D) A specific description of the course of treatment and each medical service delayed, modified or denied in whole or part.

(E) A clear and concise explanation of the reasons for the decision to delay, modify or deny each item requested.

(F) A description of the medical criteria or guidelines relied upon by the reviewer, whether the medical director, expert reviewer or reviewer, in making the decision and a copy of the relevant page(s) or section(s) of such guidelines or criteria.

(G) The clinical reasons provided by the reviewer, whether the medical director, expert reviewer or reviewer, regarding medical necessity.

(H) A clear statement that any dispute shall be resolved in accordance with the provisions of Labor Code section 4062 and that an objection to the utilization review decision must be communicated by the injured worker or the injured worker's attorney, if any, to the claims administrator in writing within 20 calendar days of receipt of the decision. It shall further state that the 20-day time limit may be extended for good cause or by mutual agreement of the parties. The letter shall further state the injured worker may file an Application for Adjudication of Claim and Request for Expedited Hearing, DWC Form 4, showing a bona fide

dispute as to entitlement to medical treatment in accordance with sections 10136(b)(1), 10400, and 10408.

(I) The following mandatory language:

"If you want further information, you may contact the local DWC Information and Assistance office by calling [enter district Information & Assistance office telephone number closest to the injured worker] or you may receive recorded information by calling 1-800-736-7401.

“You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits."

(J) The name of the reviewer relied on to make the decision modifying, delaying or denying the requested treatment authorization, along with the reviewer’s current license(s), area(s) of certified specialty, area(s) of practice, address, telephone number, and hours of availability.

(5) For prospective or concurrent review, for each failure of the claims administrator, to make a decision within 5 working days from the date of receipt of the information necessary to make the determination, and in no event more than 14 calendar days from the date of the request for authorization of medical services made by the employee’s physician or by the provider of services or goods identified in the request for authorization:

(A) $200 for 10 or fewer violations;

(B) $800 for 11 to not more than 20 violations;

(C) $3,200 for 21 to not more than 40 violations;

(D) $6,400 for more than 40 violations.

(6) For prospective or concurrent review, for each failure of the claims administrator to communicate to the requesting physician the decision to approve the requested authorization within 24 hours of the decision, as required by Labor Code section 4610(g)(3)(A):

(A) $100 for 10 or fewer violations;

(B) $400 for 11 to not more than 20 violations;

~~(C) $1,600 for 21 to not more than 40 violations;~~

~~(D) $3,200 for more than 40 violations.~~

~~(7) For each failure of the claims administrator to send written communication of the decision to modify, delay or deny in whole or in part the requested medical services, to the requesting physician, the provider of goods or services identified in the request for authorization, to the injured employee, and to his her attorney, if any, within twenty four (24) hours of making the decision, for concurrent review, or within two business days for prospective review:~~

~~(A) $100 for 10 or fewer violations;~~

~~(B) $400 for 11 to not more than 20 violations;~~

~~(C) $1,600 for 21 to not more than 40 violations;~~

~~(D) $3,200 for more than 40 violations.~~

~~(8) For retrospective review, for each failure of the claims administrator to communicate a decision to the requesting physician, the provider of goods or services identified in the request for authorization, to the injured worker, and to his or her attorney, if any, within 30 calendar days of receipt of the information that is reasonably necessary to make the determination:~~

~~(A) $100 for 10 or fewer violations;~~

~~(B) $400 for 11 to not more than 20 violations;~~

~~(C) $1,600 for 21 to not more than 40 violations;~~

~~(D) $3,200 for more than 40 violations.~~

~~(9) For each failure by the claims administrator to provide written notice immediately to the requesting physician, to the injured employee, and to his or her attorney, if any, that a decision on the request for authorization cannot be made within fourteen (14) days for prospective and concurrent reviews, or within thirty (30) days for retrospective reviews for one of the reasons stated in Labor Code section 4610(g)(5):~~

~~(A) $100 for 10 or fewer violations;~~

~~(B) $400 for 11 to not more than 20 violations;~~

(C) $1,600 for 21 to not more than 40 violations;

(D) $3,200 for more than 40 violations.

(10) For each instance in which a claims administrator, in reliance on Labor Code section 4610(g)(5), delays making or communicating a timely decision or extends the time for decision pursuant to section 9792.9 of these regulations on a request for authorization for medical services, and the claims administrator cannot provide documentation showing one of the following events occurred prior to or at the time the claims administrator communicated this reason for delay under Labor Code section 4610(g)(5):

i) the claims administrator had not received all of the information reasonably necessary and requested;

ii) the employer or claims administrator has requested a consultation by an expert reviewer;

iii) the physician reviewer has requested an additional examination or test be performed

(A) $100 for 10 or fewer violations;

(B) $400 for 11 to not more than 20 violations;

(C) $1,600 for 21 to not more than 40 violations;

(D) $3,200 for more than 40 violations.

(11) For each instance in which the claims administrator communicates a written decision in reliance on Labor Code section 4610(g)(5) to delay or extend the time for making a decision on a request for authorization for medical services, but fails to state one or more of the following, as appropriate, to explain the delay:

i) specifying the information reasonably necessary and requested but not received;

ii) the name of the expert reviewer to be consulted;

iii) the additional test(s) or examination(s) to be performed;

iv) the anticipated date on which a decision will be made.

(A) $100 for 10 or fewer violations;

(B) $400 for 11 to not more than 20 violations;

(C) $1,600 for 21 to not more than 40 violations;

(D) $3,200 for more than 40 violations.

~~(12) Following a delay or extension of time in reliance on Labor Code section 4610(g)(5), for each failure to make a decision to approve, modify, delay or deny the requested for medical services within 5 working days for prospective or concurrent review or 30 calendar days for retrospective review :~~

~~(A) $200 for 10 or fewer violations;~~

~~(B) $800 for 11 to not more than 20 violations;~~

~~(C) $3,200 for 21 to not more than 40 violations;~~

~~(D) $6,400 for more than 40 violations.~~

~~(13) Following a delay or extension of time in reliance on Labor Code section 4610(g)(5), for each failure to communicate the decision in a timely manner to the requesting physician, the provider of goods or services identified in the request for authorization, the injured worker, and his or her attorney, if any:~~

~~(A) $200 for 10 or fewer violations;~~

~~(B) $800 for 11 to not more than 20 violations;~~

~~(C) $3,200 for 21 to not more than 40 violations;~~

~~(D) $6,400 for more than 40 violations.~~

~~(14) For each failure by the claims administrator to disclose or otherwise make available the Utilization Review criteria or guidelines to the public if requested as required by Labor Code section 4610, subdivision (f)(5):~~

~~(A) $100 for 10 or fewer violations;~~

~~(B) $400 for 11 to not more than 20 violations;~~

~~(C) $1,600 for 21 to not more than 40 violations;~~

~~(D) $3,200 for more than 40 violations.~~

Authority: Sections 133, 4610, and 5307.3, Labor Code.
Reference: Sections 129, 129.5, 4062, 4600, 4600.4, 4604.5, 4610, and 4614, Labor Code.

§ 9792.13 Assessment of Administrative Penalties – Penalty Adjustment Factors.

(a) In ***any case*** ~~cases~~ that the Administrative Director deems appropriate, the Administrative Director, or his or her designee, may adjust a ***basic or graduated*** penalty ***amount*** imposed under section 9792.12 after considering each of these factors:

(1) The medical consequences or gravity of the violation(s);

(2) The good faith of the employer, insurer or other entity subject to Labor Code section 4610;

(3) The history of previous penalties for violations of Labor Code section 4610 or ~~these regulations~~ ***sections 9792.6 through 9792.12 if Title 8 of the California Code of Regulations*** ;

(4) The number and type of the violations;

(5) The size of the claims adjusting location or other facility subject to section 4610 of the Labor Code;

(6) The time period covered by the investigation~~.~~***;***

(7) The rate of violation found during the investigation giving rise to a penalty;

(8) The impact of the penalties assessed in relation to the business revenues of the entity or person subject to Labor Code section 4610; and

(9) In the event an objection or appeal is filed pursuant to subsection 9792.15 of these regulations, whether the employer, claims administrator, utilization review organization or other person performing utilization review services abated the alleged violation within the time period specified by the Administrative Director or his or her designee.

(b) ~~For each multiple instance penalty assessed pursuant to section 9792.12(b) of these regulations, penalties shall be assessed by calculating the lesser of the amount of the penalty or three times the value of the sum of all requested medical services included in each group of violations resulting in a multiple instance penalty assessment.~~

(b) Upon finding in three separate investigations at the same location that a claims administrator, utilization review organization or other person performing utilization review services for any employer, has violated the same section under Labor Code section 4610 or sections 9792.6 through 9792.12 of Title 8 of the California Code of Regulations, the Administrative

Director, or his or her designee, shall pursue any remedy that may be obtained pursuant to Business and Professions Code sections 17200 et. seq. as well as any other statute or regulation that may apply.

(c) The Administrative Director, or his or her designee, may assess both an administrative penalty under Labor Code section 4610 and a civil penalty under subdivision (e) of Labor Code section 129.5 based on the same violation(s).

(d) Where an injured worker's or a requesting provider's refusal to cooperate in the utilization review process has prevented the claims administrator from determining whether there is a legal obligation to perform an act, the Administrative Director, or his or her designee, may forego a penalty assessment for any related act or omission. ***The claims administrator, utilization review organization or other person assessed a proposed penalty pursuant to sections 9792.12 of Title 8 of the California Code of Regulations shall have the burden of proof in establishing both the refusal to cooperate and that such refusal prevented compliance with the relevant applicable statute or regulation.***

(e) Nothing in these regulations shall bar the assessment of a separate civil penalty under Labor Code section 129.5(e).

Authority: Sections 133, 4610, and 5307.3, Labor Code.
Reference: Sections 129, 129.5, 4062, 4600, 4600.4, 4604.5, 4610, and 4614, Labor Code.

§ 9792.14 Liability for Penalty Assessments.

(a) If more than one claims administrator***, utilization review organization*** or other entity subject to Labor Code section 4610 has been responsible for a claim file, utilization review file or other file that is being investigated or audited, penalties may be assessed against each such entity for the violation(s) that occurred during the time each such entity had responsibility for the file or for the utilization review process.

(b) The claims administrator***, utilization review organization*** or other entity subject to Labor Code section 4610***, respectively,*** is liable for all penalty assessments ***made against it***, except that if the subject of the investigation or audit is acting as an agent, the agent ***and the principal are*** ~~is~~ jointly and severally liable ~~with the liable entity~~ for all penalty assessments ***resulting from a given investigation or audit***. This paragraph does not prohibit an agent and its principal from allocating the administrative penalty liability between them. Liability for civil penalties assessed pursuant to Labor Code section 129.5(e) for

violations under Labor Code section 4610 or sections 9792.6 through 9792.10 of Title 8 of the California Code of Regulations shall not be allocated.

(c) Successor liability may be imposed on a claims administrator***, utilization review organization*** or other entity responsible for administering the utilization review process, that has merged with, consolidated, or otherwise continued the business of a corporation ~~or~~ ***,*** other business entity ***or other person*** that ~~is~~ ***was cited by the Administrative Director for violations of Labor Code section 4610 or sections 9792.6 through 9792.12.*** ~~a responsible party and failed to meet its obligations under Divisions 1 and 4 of the Labor Code or regulations of the Administrative Director.~~ The surviving entity ***or person*** responsible for administering the utilization review process ***for an employer***, shall assume and be liable for all the liabilities, obligations and penalties of the prior corporation or business entity. Successor liability will be imposed if there has been a substantial continuity of business operations and/or the new business uses the same or substantially the same work force.

Authority: Sections 133, 4610, and 5307.3, Labor Code.
Reference: Sections 129, 129.5, 4062, 4600, 4600.4, 4604.5, 4610, and 4614, Labor Code.

§ 9792.15 Administrative Penalties Pursuant to Labor Code §4610 - Order to Show Cause, Notice of Hearing, Determination and Order, and Review Procedure.

(a) Pursuant to Labor Code section 4610(i), the Administrative Director shall issue an Order to Show Cause Re: Assessment of Administrative Penalty and Notice of Hearing when the Administrative Director, or his or her designee (the investigating unit of the Division of Workers' Compensation), has reason to believe that an employer, insurer or other entity subject to Labor Code section 4610 has failed to meet any of the requirements of this section or of any regulation adopted by the Administrative Director pursuant to the authority of section 4610.

(b) The order shall be in writing and shall contain all of the following:

(1) Notice that an administrative penalty may be assessed;

(2) The basis for the assessment, including a statement of the alleged violations and the amount of each proposed penalty;

(3) Notice of the date, time and place of a hearing. Continuances will not be allowed without a showing of good cause.

(c) The order shall be served personally or by registered or certified mail.

(d) Within five (5) business days of receipt of an Order to Show Cause re: Assessment of Administrative Penalties, the claims administrator, ***utilization review organization*** or other ~~entity~~ ***or person*** responsible for performing utilization review processes for the employer, shall serve by certified mail a complete copy of the Order on the employer, if different than the claims administrator.

(e) Within 30 calendar days after the date of service of the Order to Show Cause Re Assessment of Administrative Penalties, the employer, insurer***, utilization review organization*** or other entity ***or person subject to Labor Code section 4610*** may pay the assessed administrative penalties or file ***an answer***, as the respondent, with the Administrative Director ~~an answer~~, in which the respondent may:

(1) Admit or deny in whole or in part any of the allegations set forth in the Order to Show Cause;

(2) Contest the amount of any or all proposed administrative penalties;

(3) Contest the existence of any or all of the alleged violations;

(4) Set forth any affirmative and other defenses;

(5) Set forth the legal and factual bases for each defense. ~~Any allegation and proposed penalty stated in the Order to Show Cause that is not appealed shall be paid within thirty (30) calendar days after the date of service of the Order to Show Cause.~~

(f) Any allegation and proposed penalty stated in the Order to Show Cause that is not appealed shall be paid within thirty (30) calendar days after the date of service of the Order to Show Cause.

~~(f)~~ ***(g)*** Failure to timely file an answer shall constitute a waiver of the respondent's right to an evidentiary hearing. Unless set forth in the answer, all defenses to the Order to Show cause shall be deemed waived. If the answer is not timely filed, within ten (10) days of the date for filing the answer, the respondent may file a written request for leave to file an answer. The respondent may also file a written request for leave to assert additional defenses, which the Administrative Director may grant upon a showing of good cause.

~~(g)~~ ***(h)*** The answer shall be in writing signed by, or on behalf of, the employer, insurer***, utilization review organization*** or other entity ***or person*** subject to Labor Code~~s~~ section 4610, and shall state the respondent's mailing address. It

need not be verified or follow any particular form. In the event the respondent is not the employer, the employer's address shall be provided and the employer shall be included on the proof of service.

(1) The respondent must file the original and one copy of the answer on the Administrative Director and concurrently serve one copy of the answer on the investigating unit of the Division of Workers' Compensation (designated by the Administrative Director). The original and all copies of any filings required by this section shall have a proof of service attached.

~~(h)~~ ***(i)*** At any time before the hearing, the Administrative Director may file or permit the filing of an amended complaint or supplemental Order to Show Cause. All parties shall be notified thereof. If the amended complaint or supplemental Order to Show Cause presents new charges, the Administrative Director shall afford the respondent a reasonable opportunity to prepare its defense, and the respondent shall be entitled to file an amended answer.

~~(i)~~ ***(j)*** At the Administrative Director's discretion, the Administrative Director may proceed with an informal pre-hearing conference with the respondent in an effort to resolve the contested matters. If any or all of the ~~charges~~ ***violations alleged*** or proposed penalties in the Order to Show Cause, the amended Order or the supplemental Order remain contested, those contested matters shall proceed to an evidentiary hearing.

~~(j)~~ ***(k)*** Whenever the Administrative Director's Order to Show Cause has been contested, the Administrative Director may designate a hearing officer to preside over the hearing. The ***authority of the*** Administrative Director's, ~~and~~ ***or*** any designated hearing officer~~'s, authority includes~~ ***shall include***, but is not limited to: conducting a prehearing settlement conference; setting the date for an evidentiary hearing and any continuances; issuing subpoenas for the attendance of any person residing anywhere within the state as a witness or party at any pre-hearing conference and hearing; issuing subpoenas duces tecum for the production of documents and things at the hearing; presiding at the hearings; administering oaths or affirmations and certifying official acts; ruling on objections and motions; issuing prehearing orders; and preparing a Recommended Determination and Opinion based on the hearing.

~~(k)~~ ***(l)*** The Administrative Director, or the designated hearing officer, shall set the time and place for any prehearing conference on the contested matters in the Order to Show Cause, and shall give reasonable written notice to all parties.

~~(l)~~ ***(m)*** The prehearing conference may address one or more of the following matters:

(1) Exploration of settlement possibilities;

(2) Preparation of stipulations;

(3) Clarification of issues;

(4) Rulings on ***the*** identity ***of witnesses*** and limitation of the number of witnesses;

(5) Objections to proffers of evidence;

(6) Order of presentation of evidence and cross-examination;

(7) Rulings regarding issuance of subpoenas and protective orders;

(8) Schedules for the submission of written briefs and schedules for the commencement and conduct of the hearing;

(9) Any other matters as shall promote the orderly and prompt conduct of the hearing.

~~(m)~~ ***(n)*** The Administrative Director, or the designated hearing officer, shall issue a prehearing order incorporating the matters determined at the prehearing conference. The Administrative Director, or the designated hearing officer, may direct one or more of the parties to prepare the prehearing order.

~~(n)~~ ***(o)*** Not less than ***thirty (***30***)*** calendar days prior to the date of the evidentiary hearing, the respondent shall file and serve the original and one copy of a written statement with the Administrative Director, or the designated hearing officer, specifying the legal and factual bases for its answer and each defense, listing all witnesses the respondent intends to call to testify at the hearing, and appending copies of all documents and other evidence the respondent intends to introduce into evidence at the hearing. A copy of the written statement and its attachments shall also concurrently be served on the investigating unit of the Division of Workers' Compensation. If the written statement and supporting evidence are not timely filed and served, the Administrative Director, or the designated hearing officer, shall dismiss the answer and issue a written Determination based on the evidence provided by the investigating unit of the Division of Workers' Compensation. Within ten (10) calendar days of the date for filing the written statement and supporting evidence, the respondent may file a written request for leave to file a written statement and supporting evidence. The Administrative Director, or the designate hearing officer, may grant the request, upon a showing of good cause. If leave is granted, the written statement and supporting evidence must be filed and served no later than ten (10) calendar days prior to the date of the hearing.

~~(o)~~ ***(p)*** Oral testimony shall be taken only on oath or affirmation.

~~(p)(1)~~ ***(q)(1)*** Each party shall have these rights: to call and examine witnesses, to introduce exhibits; to cross-examine opposing witnesses on any matter relevant to the issues even though that matter was not covered in the direct examination; to impeach any witness regardless of which party first called him or her to testify; and to rebut the evidence.

(2) In the absence of a contrary order by the Administrative Director, or the designated hearing officer, the investigating unit of the Division of Workers' Compensation shall present evidence first.

(3) The hearing need not be conducted according to the technical rules relating to evidence and witnesses, except as hereinafter provided. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of the evidence over objection in civil actions.

(4) Hearsay evidence may be used for the purpose of supplementing or explaining other evidence but ~~over~~ ***upon*** timely objection shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions. An objection is timely if made before submission of the case to the Administrative Director, or to the designated hearing officer.

~~(q)~~ ***(r)*** The written affidavit or declaration of any witness may be offered and shall be received into evidence provided that (i) the witness was listed in the written statement pursuant to section 9792.13(m); (ii) the statement is made by affidavit or by declaration under penalty of perjury; (iii) copies of the statement have been delivered to all opposing parties at least 20 days prior to the hearing; and (iv) no opposing party has, at least 10 days before the hearing, delivered to the proponent of the evidence a written demand that the witness be produced in person to testify at the hearing. The Administrative Director, or the designated hearing officer, shall disregard any portion of the statement received pursuant to this regulation that would be inadmissible if the witness were testifying in person, but the inclusion of inadmissible matter does not render the entire statement inadmissible. ***Upon timely demand for production of a witness in lieu of admission of an affidavit or declaration, the proponent of that witness shall ensure the witness appears at the scheduled hearing and the proffered declaration or affidavit from that witness shall not be admitted.***

~~(r)~~ ***(s)*** The Administrative Director, or the designated hearing officer, shall issue a written ~~Recommended~~ Determination and Order Assessing Penalty, if any, including a statement of the basis for the Determination and each penalty

assessed, within 60 days of the date the case was submitted for decision, which shall be served on all parties. This requirement is directory and not jurisdictional.

~~(s)~~ ***(t)*** The Administrative Director shall have sixty (60) calendar days to adopt or modify the Determination and Order Assessing Penalty issued by the designated hearing officer. In the event the ~~R~~ ***r***ecommended Determination and Order of the designated hearing officer is modified, the Administrative Director shall include a statement of the basis for the Final Determination and Order Assessing Penalty ***signed and served by the Administrative Director, or his or her designee.***

~~(t)~~ ***(u)*** The Final Determination and Order Assessing Penalty, if any, shall become ~~the~~ final for the purposes of review within twenty (20) days of the date it was served or deemed adopted, unless the aggrieved party files a timely Petition Appealing Determination of the Administrative Director. All findings and assessments in the Final Determination and Order Assessing Penalty not contested in the Petition Appealing Determination of the Administrative Director shall become final as though no petition was filed.

~~(u)~~ ***(v)*** At any time prior to the date the Final Determination and Order Assessing Penalty becomes final, the Administrative Director, or designated hearing officer, may correct the Final Determination and Order Assessing Penalty for clerical, mathematical or procedural error, or amend the Final Determination or Order Assessing Penalty for good cause.

~~(v)~~ ***(w)*** Penalties assessed in a Final Determination and Order Assessing Penalty shall be paid within thirty (30) calendar days of the date the Final Determination and Order became final. A timely filed Petition Appealing Determination of the Administrative Director shall toll the period for paying the penalty assessed for the item appealed.

~~(w)~~ ***(x)*** All appeals from any part or the entire Final Determination and Order Assessing Penalty shall be made in the form of a Petition Appealing Determination of the Administrative Director, in conformance with the requirements of chapter 7, part 4 of Division 4 of the Labor Code. Any such Petition Appealing Determination of the Administrative Director shall be filed at the Appeals Board in San Francisco (and not with any district office of the Workers' Compensation Appeals Board), in the same manner specified for petitions for reconsideration.

Authority: Sections 133, 4610, and 5307.3, Labor Code.
Reference: Sections 129, 129.5, 4062, 4600, 4600.4, 4604.5, 4610, 4614, and 5300 Labor Code.